STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	01	COMPLI	ETED
		155747	B. WIN			11/13/	2012
			b. Wilt		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ERCER AVE		
WOODC	REST NURSING CI	ENTER			UR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0000							
	A Post Survey F	Revisit (PSR) to the	K00	000	Preparation and execution of t	his	
	Life Safety Cod	e Recertification,			plan of correction does not		
	State Licensure	and Quality			constitute admission or agreement by the provider of t	ho	
	Assurance Wall				truth of the facts alleged or the		
	conducted on (conclusions set forth in the		
		he Indiana State			Statement of Deficiencies		
	=				rendered by the reviewing		
	Department of				agency. The Plan of Correction	n is	
	accordance wit	h 42 CFR 483.70(a).			prepared and executed solely		
					because it is required by the provisions of federal and state		
	Survey Date: 1	1/13/12			law. Woodcrest Nursing Cent		
					maintains that the alleged	01	
	Facility Numbe	r: 000556		deficiencies do not individually or		or	
	Provider Numb		collectively jeopardize the health				
	AIM Number:				and/or the safety of its residen		
	All Nulliber.	100290130			nor are they of such character		
					to limit the provider's capacity		
		Kelley, Life Safety			render adequate resident care Furthermore, Woodcrest Nursi		
	Code Specialist	İ			Center asserts that it is in	iig	
					substantial compliance with		
	At this PSR sur	vey, Woodcrest			regulations governing the		
	Nursina Center	was found not in			operation of long term care		
		h Requirements for			facilities, and this Plan of		
	Participation in	•			Correction in its entirety		
	•				constitutes this provider's		
	Medicare/Medi				allegation of compliance and, thereby, we request resurvey t	·o	
	-	O(a), Life Safety			verify such as of November 15		
	from Fire and t	he 2000 edition of			, 2012. Further, we request		
	the National Fi	re Protection			desk review (paper		
	Association (NI	FPA) 101, Life Safety			compliance) for compliance,	if	
	Code (LSC) and	l 410 IAC 16.2. The			acceptable. Completion dates		
		of the building			are provided for procedural	.	
	_	Wing, C Wing, the			processing purposes to comp		
	_	-			with federal and state regulation and correlate with the most reconstruction.		
	Exterioed Care	Wing and the main			contemplated or accomplished		
			1		I sourcemplated of accomplished	4	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000556

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED	
		155747	B. WIN			11/13/2012	
NAME OF P	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ERCER AVE		
WOODCI	REST NURSING C	ENTER		DECAT	UR, IN 46733		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		ON
TAG		R LSC IDENTIFYING INFORMATION)	+	TAG	corrective action. These do no	DATE	
	dining room was surveyed with				necessarily chronologically		
		isting Health Care			correspond to the date that		
	Occupancies.				Woodcrest Nursing Center is		
		6 11.			under the opinion that it was ir compliance with the requirement		
	This one story	· · · · · · · · · · · · · · · · · · ·		of participation or that corrective			
	determined to be of Type V (111)				action was necessary.		
	construction a	•					
	· ·	he facility has a fire					
	alarm system v						
		orridors, areas open					
		s and hard wired					
		ors in the resident					
		cility has a capacity					
		d a census of 125 at					
	the time of thi	s survey.					
	The facility wa	s found in					
	compliance wi						
		ikler coverage and					
	smoke detecto						
	Jilloke detecto	i coverage.					
	 All areas where	e the residents have					
	customary acc						
	sprinklered. A						
	I -	s were sprinklered.					
	-	•					
		Robert Booher, Life Safety					
	Code Specialist-Me	edical Surveyor on 11/15/12.					
	- C	6 1					
	The facility wa						
	compliance wi						
	aforementione	- ·					
	requirements a	as evidenced by the					
	1		1	J		1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ZUI22

Facility ID: 000556

If continuation sheet

Page 2 of 12

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155747	(X2) MULTIPLE CO A. BUILDING B. WING	01		LETED B/2012
WOODC	PROVIDER OR SUPPLIER	ENTER	1300 M DECAT	ADDRESS, CITY, STATE, ZIP C ERCER AVE UR, IN 46733	CODE	
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	following:					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5ZUI22

Facility ID: 000556

If continuation sheet

Page 3 of 12

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155747 NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING CENTER WOODCREST NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION) KO144 NFPA 101 Sased on observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station. NFPA 99, Health Care Facilities, 3-4-1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. NFPA 99, Health Care Facilities, 3-4-1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES PREFEX DECATUR, IN 46733 SUMMARY STATEMENT OF DEFICIENCIES PREFEX DECATUR, IN 46733 SUMMARY STATEMENT OF DEFICIENCIES PREFEX DECATUR, IN 46733 ID BECATUR, IN 46733 ID BECATUR, IN 46733 CASI- REGULATORY OR LSC IDENTIFYING INFORMATION) A SUBJECT OURSERTINA TO CORRECTION PREFEX DECATUR, IN 46733 ID BECATUR, IN 46733 CASI- REGULATORY OR LSC IDENTIFYING INFORMATION) A SUBJECT OURSERTINA TO CORRECTION PREFEX DECATUR, IN 46733 ID BECATUR, IN 46733 CASI- REGULATORY OR LSC IDENTIFYING INFORMATION) A SUBJECT OURSERTINA TO CORRECTION PREFEX DECATUR, IN 46733 ID BECATUR, IN 46733 IN 41. 1. What corrective action(s) will be accomplished to the eaccomplished of the generation of the wall across form "A" wing nurses' station (mance deficient practice? The remote generator annuciator and interest of t	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY	
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NFPA 99, Health Care Facilities, 3–4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall by contractor. The remote annunciator panel which was relocated meets the following criteria - [NFPA 99, Health Care Facilities, 3-4.1.1.15 requirement] storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall		=	-			1		
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observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:(a) Individual visual signals shall indicate: 1. When the emergency or auxiliary		room in a locat	ion readily				tne	
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annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: source as follows:(a) Individual visual signals shall indicate: 1. When the emergency or auxiliary			- .			, , , , ,		
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auxiliary power source as follows: (a) Individual visual signals shall (b) Individual visual signals shall (a) When the emergency or auxiliary							е	
(a) Individual visual signals shall visual signals shall indicate: 1. When the emergency or auxiliary								
When the emergency or auxiliary						` '		
		(a) Individual vi	isual signals shall					
indicate: power source is operating to		indicate:					ui y	
1. When the emergency or supply power to load. 2. When		1. When the en	nergency or				n	
auxiliary power source is the battery charger is		auxiliary power	r source is			the battery charger is		
operating to supply power to load. malfunctioning (b) Individual		operating to su	ipply power to load.			O \ /		
2. When the battony charger is		· ·						
audible signal to want of all			· · · · · · · · · · · · · · · · · · ·			_	ion	
		-						
cil propouro 2 Louwester							ษ	
common audible signal to warn of temperature. 3. Excessive water		common audib	ie signal to warn of				er	

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Event ID: 5ZUI22

Facility ID: 000556

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	01	COMPLETED
		155747	B. WIN			11/13/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	£		1300 M	ERCER AVE	
	REST NURSING C				UR, IN 46733	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	temperature. 4. Low fuel - whe	DATE
	an engine-gen				the main fuel storage tank	
	condition shall indicate: 1. Low lubricating oil pressure.				contains less than a 3-hour	
					operating supply. 5. Overcranl	
	2. Low water to	emperature.			(failed to start). 6. Overspeed.	
	3. Excessive w	ater temperature.			previous arrangement installed	
	4. Low fuel – w	hen the main fuel			upon the building of the facility and subsequent Fire Marshall	
	storage tank c	ontains less than a			and LSC surveys was previous	
	3-hour operati	ing supply.			uncited and thereby compliant	. <u>2.</u>
	5. Overcrank (1	- · · ·			How will the facility identify oth	
	6. Overspeed.				residents having the potential be affected by the same allege	
	· ·	r work station will			deficient practice and what	<u>;u</u>
	be unattended periodically, an				corrective action will be taken?	2
		sual derangement			None were so identified. 3. Wh	
		riately labeled, shall			measures will be put into place	
		at a continuously			what systemic changes will be	= '
	monitored loca	•			made to ensure that the allege deficient practice does not rec	
					The measures put in place we	
	_	signal shall activate			the relocation of the actual	
	Ī	e conditions in			remote annunciator panel as	.,,
		and (b) occur but			ellicited in (1.) above. 4. How very the corrective actions be	<u>/////</u>
	<u>-</u>	ay these conditions			monitored to ensure that the	
	individually. T				deficient practice does not rec	ur?
	practice could	affect all occupants.			The relocation is permanent, t	
					no further action would be	
	Findings includ	de:			required as regards the location of the annunciator panel.	on
					or the annunctator parier.	
	Based on an ol	oservation with the				
	Vice President	of Long Term Care,				
	Maintenance T	echnician # 1, and				
	Maintenance T	echnician # 2 on				
	11/13/12 at 1	2:57 p.m., the				
		nerator did have a				
		ciator panel located				
		I room across from				

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Event ID: 5ZUI22

Facility ID: 000556

If continuation sheet

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155747	LDING	NSTRUCTION 01	(X3) DATE COMPL 11/13/	ETED
	PROVIDER OR SUPPLIER		1300 ME	DDRESS, CITY, STATE, ZIP CODE ERCER AVE UR, IN 46733		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	(X5) COMPLETION DATE
	not continuous trouble light for annunciator parties A wing nur was continuou asked if the trowhen there is a generator, Mai Technician # 2 time the switch generator was mode. There was audible/visual annunciator partight at the nur alarm. This work Vice President at the time of of this deficiency 09/19/12. The implement a system.	said "no." At this nat the emergency switched to manual was an alarm at the remote anel but the trouble rees' station did not as confirmed by the of Long Term Care observation.				

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Event ID: 5ZUI22

Facility ID: 000556

If continuation sheet

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747 NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING CENTER INAME OF PROVIDER OR SUPPLIER WOODCREST NURSING CENTER INAME OF PROVIDER OR SUPPLIER INAME OF PROVIDER OR SUPPLIER WOODCREST NURSING CENTER INAME OF PROVIDER OR SUPPLIER INAME OR SUPPLIER INAME OF PROVIDER OR SUPPLIER INAME OF PROVIDER OR OR SUPPLIER INAME OF PROVIDER OR SUPPLIER IN MACCHOBAL PROVIDED OR SUPPLIED OR SUPPLIED OR SUPPLIED IN MACCHOBAL PROVIDED OR SUPPLIED OR	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING CENTER BURNARY STATEMENT OF DEFICIENCES TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A Post Survey Revisit (PSR) to the Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Surveys conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 11/13/12 Facility Number: 000556 Provider Number: 155747 AIM Number: 100290130 Surveyor: Amy Kelley, Life Safety Code Specialist At this PSR survey, Woodcrest Nursing Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety Code (LSC) and 410 IAC 16.2. The SIRRET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN 46733 IN 406038 SURVEYOR AVE DECATUR, IN 46733 IN 406038 FROUDESTRANCY CORRESTOR AVE DECATUR, IN 46735 FROUDESTRANCY CORRESTOR AVE DECATUR, IN 46735 IN 406038 FROUDESTRA	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	DING	02	COMPLETED	
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DECATUR, IN 46733 DECATUR, IN 46734 DECA	NAME OF P	ROVIDER OR SUPPLIEF	₹					
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Code (LSC) and 410 IAC 16.2. The acceptable. Completion dates		the National Fi	re Protection					
		Association (N	FPA) 101, Life Safety					
		Code (LSC) and	d 410 IAC 16.2. The			· · · · · · · · · · · · · · · · · · ·	s	
						are provided for procedural	.	
processing purposes to comply								
pool, apartment, nurses' station with federal and state regulations, and correlate with the most recent			-			_		
contemplated or accomplished		poor, apartifier	it, iiui ses station					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155747	A. BUI	LDING	NSTRUCTION 02	(X3) DATE : COMPL 11/13/	ETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE ERCER AVE UR, IN 46733		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Chapter 18, Net Occupancies. This one story determined to construction as sprinklered. Talarm system with detection in costo the corridors smoke detectorooms. The facility was compliance with regard to sprinklered. All areas where customary accessprinklered. A facility services. The facility was compliance with a facility was compliance with a facility services.	facility was be of Type V (111) and was fully he facility has a fire with smoke rridors, areas open is and hard wired rs in the resident acility has a capacity If a census of 125 at is survey. If found in h state law in kler coverage and hard coverage. If the residents have heres were hereas providing hereas were sprinklered. If found not in here is the the the coverage is were sprinklered. If found not in here is the the the coverage is found not in here is found not in here is the the coverage is found not in here is the the coverage is found not in here is the the coverage is found not in here is the the coverage is found not in here is the coverage is the coverage is found not in here is the coverage is			corrective action. These do not necessarily chronologically correspond to the date that Woodcrest Nursing Center is under the opinion that it was it compliance with the requirem of participation or that correct action was necessary.	n ents	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/21/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER: 155747	(X2) MULTIPLE CO A. BUILDING B. WING	02	(X3) DATE SURVEY COMPLETED 11/13/2012				
	ROVIDER OR SUPPLIER REST NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN 46733						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION				

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Facility ID: 000556

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/13/2012		
	ROVIDER OR SUPPLIER		D. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE ERCER AVE UR, IN 46733		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K0144 SS=F	exercised under lamonth in accordance 3.4.4.1. Based on observing interview, the feasure 1 of 1 endings and alarm annunciate readily observed personnel at a station such as NFPA 99, Health 3–4.1.1.15 requannunciator, stopowered, shall operate outside room in a locate observed by operate ou	spected weekly and boad for 30 minutes per noce with NFPA 99. Evation and facility failed to emergency a provided with an attor in a location and by operating regular work a nurses' station. The facilities, uires a remote orage battery be provided to be of the generating from readily perating personnel rk station. The fall indicate alarm fine emergency or a source as follows: sual signals shall the source is apply power to load. Ittery charger is	K01	.44	1. What corrective action(s) wibe accomplished for the resident(s) found to be affecte by the alleged deficient practic. The remote generator annucia panel was physically relocated from the entrance room to the wall across from "A" wing nurs station (manned 24/7/365) on December 15th by contractor. The remote annunciator panel which was relocated meets the following criteria - [NFPA 99, Health Car Facilities, 3-4.1.1.15 requirements storage battery powered, shall provided to operate outside of generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:(a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning.(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm conditioning-generator alarm conditioning ressure. 2. Low water temperature. 3. Excessive water	d ee? ttor t ses' re ent] be the e ary n	11/15/2012

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DI 111	LDING	02	COMPL	ETED
		155747	B. WIN			11/13/	2012
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ERCER AVE		
WOODC	REST NURSING C	ENTER		DECATUR, IN 46733			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	ì ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	•		DATE
	an engine-gen	erator alarm			temperature. 4. Low fuel - whe the main fuel storage tank	en	
	condition shall	indicate:			contains less than a 3-hour		
	 Low lubricating oil pressure. 				operating supply. 5. Overcrant	(
	2. Low water temperature.				(failed to start). 6. Overspeed.	The	
	3. Excessive wa	ater temperature.			previous arrangement installed		
	4. Low fuel – w	hen the main fuel			upon the building of the facility and subsequent Fire Marshall		
		ontains less than a			and LSC surveys was previous		
	3-hour operati				uncited and thereby compliant		
	5. Overcrank (f				How will the facility identify oth		
	6. Overspeed.	aned to start).			residents having the potential		
	·				be affected by the same allege	<u>ed</u>	
	_	r work station will			deficient practice and what	,	
		periodically, an			corrective action will be taken? None were so identified.3. Wh	_	
		sual derangement			measures will be put into place		
		riately labeled, shall			what systemic changes will be		
	be established	at a continuously			made to ensure that the allege		
	monitored loca	ation. This			deficient practice does not rec		
	derangement s	signal shall activate			The measures put in place we the relocation of the actual	re	
	when any of th	e conditions in			remote annunciator panel as		
	3-4.1.1.15(a) a	and (b) occur but			ellicited in (1.) above. <u>4. How was a second to the control of th</u>	/ill_	
	need not displa	ay these conditions			the corrective actions be		
	individually. T	-			monitored to ensure that the		
		affect all occupants.			deficient practice does not rec		
	practice could	arrect air occupants.			The relocation is permanent, to no further action would be	ius	
	Findings includ	do:			required as regards the location	n	
	Findings includ	ie.			of the annunciator panel.		
	Based on an ol	oservation with the					
	Vice President	of Long Term Care,					
		echnician # 1, and					
		echnician # 2 on					
	11/13/12 at 1						
		nerator did have a					
	, , ,						
		ciator panel located					
	ın the electrica	l room across from					

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	OF CORRECTION IDENTIFICATION NUMBER: 155747	(X2) MULTIPLE CO A. BUILDING B. WING	02	(X3) DATE SURVEY COMPLETED 11/13/2012			
	PROVIDER OR SUPPLIER REST NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN 46733					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)				
	the main dining room which was not continuously occupied. A trouble light for the generator annunciator panel was located at the A wing nurses' station which was continuously occupied. When asked if the trouble light alarms when there is a problem with the generator, Maintenance Technician #2 said "no." At this time the switch at the emergency generator was switched to manual mode. There was an audible/visual alarm at the remote annunciator panel but the trouble light at the nurses' station did not alarm. This was confirmed by the Vice President of Long Term Care at the time of observation. This deficiency was cited on 09/19/12. The facility failed to implement a systemic plan of correction to prevent recurrence. 3–1.19(b)						

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